TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MEMORIAL COMPOUNDING PHARMACY

Respondent Name
NEW HAMPSHIRE INSURANCE COMPANY

MFDR Tracking Number
M4-17-1551-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 25, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached bills have been denied by the carrier . . . The reconsideration was sent on two separate occasions with no response. We are now requesting Medical Fee Dispute Resolution."

Amount in Dispute: $1,335.94

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "we have escalated the bills in question for manual review to determine if additional monies are owed. . . . Supplemental response will be provided once the bill auditing company has finalized their review. . . Attached is a copy of all bills received to date, and their corresponding EOB's and payment details."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 29, 2016	Pharmacy services – compound drugs dispensed	$1,335.94	$1,335.94

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.2 defines words and terms related to medical billing and processing.
3. 28 Texas Administrative Code §133.10 sets out requirements regarding medical billing forms and formats.
4. 28 Texas Administrative Code §133.20 sets out requirements for submitting a medical bill.
5. 28 Texas Administrative Code §133.200 sets out requirements upon insurance carrier receipt of medical bills.
6. 28 Texas Administrative Code §133.210 sets out requirements regarding medical documentation.

7. 28 Texas Administrative Code §133.240 sets out procedures for medical bill payments and denials.
8. 28 Texas Administrative Code §134.502 sets out provisions regarding pharmaceutical benefits.
9. 28 Texas Administrative Code §134.503 sets out the pharmacy fee guideline.
10. 28 Texas Administrative Code §133.500 sets out electronic formats for electronic medical bill processing.
11. 28 Texas Administrative Code §133.501 sets out procedures for electronic medical bill processing.
12. Texas Labor Code §408.027 sets out provisions regarding payment of health care providers.
13. No explanations of benefits were submitted for review by either party. Despite the requestor's position statement that the claims were denied, the submitted documentation supports that the claims were rejected without being processed for payment consideration. The submitted insurance letters are claim rejection letters. They do not constitute EOBs according to the requirements of 28 Texas Administrative Code §133.240 (e) and (f). The respondent's position statement asserts, "Attached is a copy of all bills received to date, and their corresponding EOB's and payment details." However, no copies or information regarding any bills, EOBs or payment details were included with the response.
14. 28 Texas Administrative Code §133.307(d)(1) provides that the insurance carrier's response will be deemed timely if received within 14 calendar days from the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 days of the dispute notification, then the division may base its decision on the available information. No supplemental response has been received to date. Accordingly, this decision is based on the available information.
15. Rule §133.307(d)(2)(F) requires that the response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. As will be discussed further below, because the respondent has not supported that the insurance carrier took final action on the disputed bills and further failed to support that the insurance carrier communicated to the requestor sufficient denial reasons or defenses prior to the filing of the request for MFDR, the division finds below that the respondent has waived any such defenses. Any new denial reasons or defenses presented in the insurance carrier's response shall not be considered in this review.

Issues

1. Did the insurance carrier issue EOBs for the disputed pharmacy bills?
2. Did the insurance carrier properly return incomplete bills to the health care provider?
3. Did the insurance carrier timely pay, reduce, deny or take final action on the services in dispute?
4. Has the insurance carrier waived defenses to payment of the bill?
5. What is the recommended reimbursement for the disputed pharmacy services?
6. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier response states that:

   > we have escalated the bills in question for manual review to determine if additional monies are owed. . . . Supplemental response will be provided once the bill auditing company has finalized their review. . . Attached is a copy of all bills received to date, and their corresponding EOB's and payment details.

   Review of the submitted documentation finds that no copies of any bills, EOBs or information regarding payments was submitted for review. No supplemental response has been submitted to date.

   Rule §133.307(d)(1) states that:

   > The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile **within 14 calendar days** after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

   As of the date of this review, the division has not received any supplemental response information from the insurance carrier. Consequently, this decision is based on the information available at the time of review.

Rule §133.240(e), requires that:

> The insurance carrier shall send the explanation of benefits in accordance with the elements required by §133.500 and §133.501 of this title (relating to Electronic Formats for Electronic Medical Bill Processing and Electronic Medical Bill Processing, respectively) if the insurance carrier submits the explanation of benefits in the form of an electronic remittance. The insurance carrier shall send an explanation of benefits in accordance with subsection (f) of this section if the insurance carrier submits the explanation of benefits in paper form.

No EOBs have been submitted by either party for review. No information has been provided that the insurance carrier issued EOBs in accordance with the requirements of Rule §133.240(e) or (f).

2. 28 Texas Administrative Code §133.2(4) defines a complete medical bill as:

> A medical bill that contains all required fields as set forth in the billing instructions for the appropriate form specified in §133.10 of this chapter (relating to Required Billing Forms/Formats), or as specified for electronic medical bills in §133.500 of this chapter (relating to Electronic Formats for Electronic Medical Bill Processing).

Rule §133.10(f)(3) sets out the data content and elements required for a complete pharmacy medical bill. Review of the submitted pharmacy bills finds that all required fields are complete. The division concludes the disputed pharmacy bills are "complete" bills in accordance with the requirements of Rules §133.2(4) and §133.10(f)(3).

Rule §133.200(a)(1) requires that insurance carriers shall not return medical bills that are complete, unless the bill is a duplicate bill. No documentation was submitted to support that the bills were duplicates of a previously processed bill. Consequently, the division concludes the insurance carrier improperly returned copies of complete medical bills to the health care provider against the requirements of rule §133.200(a)(1).

3. While the requestor states that "The attached bills have been denied by the carrier," review of the submitted documentation finds that the insurance carrier instead *returned* the bills to the health care provider without submitting them for bill review or processing the bills for payment.

The letters state "This billing cannot be processed for payment consideration . . . " No information or documentation was requested by the carrier. Review of the submitted claim return cover letters finds that they do not meet the requirements of a paper EOB as set out in Rule §133.240(f). No documentation was provided to support electronic remittance of an explanation of benefits in accordance with the elements required by Rules §133.500 and §133.501.

Rule §133.240(a) requires that:

> An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation.

No information was provided to support that the insurance carrier took final action after conducting bill review on the complete medical bills submitted by the health care provider within 45 days, nor by the date that medical fee dispute resolution was requested. Consequently, the division concludes the insurance carrier has failed to meet the requirements of Rule §133.240(a).

4. The submitted information supports the requester's position that the pharmacy bills for the services in dispute were received by the insurance carrier or the carrier's agent.

   Rule §133.307(c)(2)(K) requires that the requestor shall provide with the request for MFDR:

   > a paper copy of each explanation of benefits (EOB) related to the dispute . . . or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB

   Rule §133.210(e) states that:

   > It is the insurance carrier's obligation to furnish its agents with any documentation necessary for the resolution of a medical bill. The Division considers any medical billing information or documentation possessed by one entity to be simultaneously possessed by the other.

   Review of the submitted information finds convincing documentation to support insurance carrier receipt of the request for an EOB. The division finds the requestor has met the requirements of Rule §133.307(c)(2)(K).

   Texas Labor Code Section 408.027(b), requires that:

   > The insurance carrier must pay, reduce, deny, or determine to audit the health care provider's claim not later than the 45th day after the date of receipt by the carrier of the provider's claim.

   Corresponding Rule §133.240(a) requires that:

   > An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation.

   Final action on a medical bill is defined in 28 Texas Administrative Code §133.2(6) as:

   (A) sending a payment that makes the total reimbursement for that bill a fair and reasonable reimbursement . . . and/or
   (B) denying a charge on the medical bill.

   Rule §133.307(d)(2)(B) requires that upon receipt of the request for medical fee dispute resolution, the respondent shall provide any missing information not provided by the requestor and known to the respondent, including:

   > a paper copy of all initial and appeal EOBs related to the dispute, as originally submitted to the health care provider in accordance with this chapter, related to the health care in dispute not submitted by the requestor or a statement certifying that the respondent did not receive the health care provider's disputed billing prior to the dispute request.

   The insurance carrier did not submit copies of any EOBS to MFDR as required by Rule §133.307(d)(2)(B).

   While the submitted evidence supports the health care provider's timely submission of the pharmacy bills to the insurance carrier, along with requests for reconsideration, no information was found to support the insurance carrier ever took final action or issued EOBs in accordance with the requirements of Rules § 133.240 (a) and (e). The division concludes the respondent failed to meet the requirements of the above rules.

   All workers' compensation insurance carriers are expected to fulfill their duty to take final action as required by law and the division's administrative rules. The insurance carrier failed to do so in this case.

   Rule §133.307(d)(2)(F) requires that:

   > The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

   The insurance carrier's failure to issue explanations of benefits to the health care provider constitutes grounds for the division to find a *waiver* of defenses at Medical Fee Dispute Resolution.

   As no information was presented to support that the insurance carrier had provided to the requestor any denial reasons or defenses in regard to the disputed services prior to the filing of the MFDR

request, the division finds the respondent has waived any such defenses. The disputed services will therefore be reviewed for payment according to applicable division rules and fee guidelines.

5. The disputed pharmacy services are in regard to the dispensing of prescription drugs with reimbursement subject to the provisions of 28 Texas Administrative Code §134.503(c), which requires that:

   The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:

   (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
      (A) Generic drugs: ((AWP per unit) × (number of units) × 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;
      (B) Brand name drugs: ((AWP per unit) × (number of units) × 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;
      (C) When compounding, a single compounding fee of $15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection; or

   (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
      (A) health care provider; or
      (B) pharmacy processing agent only if the health care provider has not previously billed the insurance carrier for the prescription drug and the pharmacy processing agent is billing on behalf of the health care provider. The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately as required by 28 Texas Administrative Code §134.502 (d)(2).

   Reimbursement for the disputed prescription drugs is calculated as follows:

   First compound dispensed February 29, 2016

Ingredient(s)	NDC & Type	Unit Price	Units	AWP Formula §134.503(c)(1)	Billed Amount §134.503(c)(2)	Lesser of (c)(1) or (c)(2)
VERSAPRO	38779252903 *Brand*	$3.20	41	($3.20 × 40.8) × 1.09 = $142.31	$102.00	$102.00
ETHOXY DIGLYCOL	38779190301 Generic	$0.34	4.2	($0.34 × 4.2) × 1.25 = $1.80	$1.44	$1.44
AMITRIPTYLINE HCL	38779018904 Generic	$18.24	1.8	($18.24 × 1.8) × 1.25 = $41.04	$31.63	$31.63
BUPIVACAINE HCL	38779052405 Generic	$45.60	1.2	($45.60 × 1.2) × 1.25 = $68.40	$48.02	$48.02
GABAPENTIN	38779246109 Generic	$59.85	3.6	($59.85 × 3.6) × 1.25 = $269.33	$188.10	$188.10
AMANTADINE HCL	38779041105 Generic	$24.23	3	($24.23 × 3) × 1.25 = $90.84	$38.46	$38.46
BACLOFEN	38779038809 Generic	$35.63	5.4	($35.63 × 5.4) × 1.25 = $240.50	$184.68	$184.68
		Total Units:	60		Subtotal:	$594.33
					+ $15 compound fee = **Total**:	$609.33

   Second compound dispensed February 29, 2016

Ingredient(s)	NDC & Type	Unit Price	Units	AWP Formula §134.503(c)(1)	Billed Amount §134.503(c)(2)	Lesser of (c)(1) or (c)(2)
BUPIVACAINE HCL	38779052405 Generic	$45.60	1.2	($45.60 × 1.2) × 1.25 = $68.40	$54.72	$54.72
ETHOXY DIGLYCOL	38779190301 Generic	$0.34	3	($0.34 × 3) × 1.25 = $1.28	$1.02	$1.02
TRAMADOL HCL	38779237409 Generic	$36.30	6	($36.30 × 6) × 1.25 = $272.25	$217.80	$217.80
CYCLOBENZAPRINE HCL	38779039509 Generic	$46.33	2	($46.33 × 2) × 1.25 = $115.83	$83.39	$83.39
MELOXICAM	38779274601 Generic	$194.67	0.2	($194.67 × 0.18) × 1.25 = $43.80	$35.04	$35.04
FLURBIPROFEN	38779036209 Generic	$36.58	5	($36.58 × 5) × 1.25 = $228.63	$175.58	$175.58
VERSAPRO	38779252903 Brand	$3.20	45	($3.20 × 45.02) × 1.09 = $157.03	$144.06	$144.06
		Total Units:	62.4		Subtotal:	$711.61
					+ $15 compound fee = **Total**:	$726.61

6. The maximum allowable reimbursement is $1,335.94. The insurance carrier has paid $1,335.94, leaving an amount due to the requestor of $1,335.94. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The Division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,335.94.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $1,335.94, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	April 6, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.